THE PULSE

BRINGING MEDICAL HUMANITARIAN ACTION TO YOU

MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS

FEBRUARY 2017

TANZANIA: REFUGEE INFLUX

RISK OF OUTBREAKS

Mental healthcare

THE WORK OF OUR PSYCHOLOGISTS

THE PULSE

FEBRUARY 2017
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CONTENTS

3 EDITORIAL: CHILDBIRTH IN AFGHANISTAN
4 NEWS IN BRIEF
6 FEATURE: TANZANIA REFUGEE INFLUX
8 PHOTO ESSAY: DADAAB
10 LETTER FROM NIGERIA
11 SUPPORTER PROFILE
12 FEATURE: MEDITERRANEAN REFUGEE CRISIS
14 FIELD WORKER: MENTAL HEALTH COORDINATOR
15 CURRENTLY IN THE FIELD

ON THE BRINK IN TANZANIA 6

LIVES IN LIMBO IN DADAAB 8

LETTER FROM BORNO STATE, NIGERIA 10

BY CLAIRE FOTHERINGHAM

© Aurelie Baumel/MSF

A young boy and his father at a Médecins Sans Frontières nutrition centre in north-east Nigeria. Read more about our work in Nigeria on page 10.

ABOUT MÉDECINS SANS FRONTIÈRES

Médecins Sans Frontières is an international, independent, medical humanitarian organisation that was founded in France in 1971. The organisation delivers emergency medical aid to people affected by armed conflict, epidemics, exclusion from healthcare and natural disasters. Assistance is provided based on need and irrespective of race, religion, gender or political affiliation.

When Médecins Sans Frontières witnesses serious acts of violence, neglected crises, or obstructions to its activities, the organisation may speak out about this.

Today, Médecins Sans Frontières is a worldwide movement of 24 associations, including one in Australia. In 2016, 203 field positions were filled by Australians and New Zealanders.

Front cover: Mother and baby in Nduta refugee camp, Tanzania. © Louise Annaud/MSF

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EDITORIAL

Safe delivery in Afghanistan

Afghanistan is one of the most dangerous places in the world to give birth. For International Women's Day 2017, Médecins Sans Frontières is putting the spotlight on pregnancy and childbirth in Afghanistan.

March 8 has always been a special day for me and my family – not only is it International Women's Day, it's also my birthday. Throughout my childhood we often celebrated my birthday by attending International Women's Day events. Perhaps that influenced my career choice as an obstetrician, ensuring that women are able to give birth safely.

One of the countries where it is most dangerous to give birth is Afghanistan. There are an estimated 396 maternal deaths for every 100,000 live births in Afghanistan. By comparison, the figure in Australia is 6 maternal deaths for every 100,000 births.

Why are Afghani women so much more likely to die during pregnancy and childbirth?

During my field placement at Médecins Sans Frontières' maternity hospital in Khost, Afghanistan, I met many women who shed some light on the complex answers to this question.

In Afghanistan, two out of every three deliveries occur at home, without any skilled birth attendant. In Khost we frequently saw women who had attempted to deliver at home before coming into the hospital with a complication, such as post-partum haemorrhage. I remember one woman who had delivered at home and then started bleeding profusely. She had been able to access a small amount of care at home, but because it was night time she was unable to travel safely to the hospital. By the time she arrived the next morning she was moribund, completely unresponsive, with a very weak pulse. And despite immediate medical attention she unfortunately passed away.

Many women now prefer to come to the hospital to deliver, but it can still be very difficult to access. They often have to travel long distances, and road travel can be extremely dangerous.

In many parts of Afghanistan there's very little availability of preventive healthcare and antenatal healthcare, so women and their carers don't always appreciate the danger signs of pregnancy and when they should seek assistance. Another issue is that the women themselves are not usually the decision makers. So even if they think they need medical care, in the end that decision is usually made by their husband and mother-in-law. Plus, women may need a male caretaker to accompany them to hospital and to consent to any surgery or family planning method.

In obstetrics, we have a mantra for the risk factors for maternal deaths: 'too early, too late, too many and too close together'. Sadly all these elements apply in Afghanistan.

Afghani women tend to get married and have children early in life, and because they are expected to have a lot of children, they often continue having babies into their 40s. Complications often occur at these two extremes of the age spectrum so our facilities see a lot of women having their first child, and a lot of women who are older, having their ninth or tenth child.

On top of that, women often don't have the capacity to space out their births because they can't access family planning, and because they are not in control of decisions around their fertility. Pregnancies that are too close together are risky for mother and baby because the woman's body may not have time to recover – for instance to replace nutrients such as iron, calcium and folate that are depleted during pregnancy.

Although the risks are unacceptably high for women giving birth in Afghanistan, Médecins Sans Frontières' work is making an impact.

In places like Khost where there is such a huge need for maternal services, our facility is well respected for the quality of care it provides. Our presence is changing attitudes around where women give birth, and the importance of having a skilled birth attendant. During my placement we held a *jirga*, a meeting with community leaders, where we discussed the idea that to be an honourable man it's important to bring your wife to hospital to ensure she has a safe delivery. We focus on caring for women with complicated deliveries, who require the high-level care that Médecins Sans Frontières can provide. In 2016 we strengthened our health promotion activities to improve recognition of complications throughout the community, including through radio messaging. We've also worked with private clinics to ensure that women with complications are swiftly referred to our hospital.

In all our projects we emphasise teaching and training local doctors and midwives, which is incredibly important because international staff come and go but the local staff stay on. Historically, lack of education of women meant there were few female doctors and midwives to look after women in labour, however culturally many families only seek care from a female. Training local female staff means that we're leaving something positive behind. And as well as training within our facilities, we've also trained midwives in local health centres to improve care of normal deliveries.

Just the sheer numbers of babies Médecins Sans Frontières delivers in its four maternity services across Afghanistan makes a huge impact. In 2016, more than 66,000 babies were delivered by our teams in Afghanistan, which equates to more than 180 babies every day. There are so many women and babies surviving as a result of Médecins Sans Frontières being in Afghanistan.

I remember one woman we assisted who was in her 40s, having her tenth child and had placenta previa – where the placenta blocks the cervix. This is quite a typical sort of patient. She had a caesarean section that not only saved her life and her baby's life, but also impacted all her other children as well. Because without their mother, they're less likely to be educated and less likely to survive. And that caesarean would have been incredibly difficult to access if Médecins Sans Frontières was not there.

Dr Claire Fotheringham
Medical Advisor – Obstetrics & Gynaecology

NEWS IN BRIEF

FOR THE LATEST MSF NEWS
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Médecins Sans Frontières has provided **13,800 cholera vaccinations** post-Hurricane Matthew in Haiti

MORE THAN **21,000 INDIVIDUAL AND GROUP MENTAL HEALTH CONSULTATIONS** WERE CONDUCTED BY MÉDECINS SANS FRONTIÈRES IN IRAQ LAST YEAR

More than **10 million litres** of clean water have been provided by tanker in Haiti

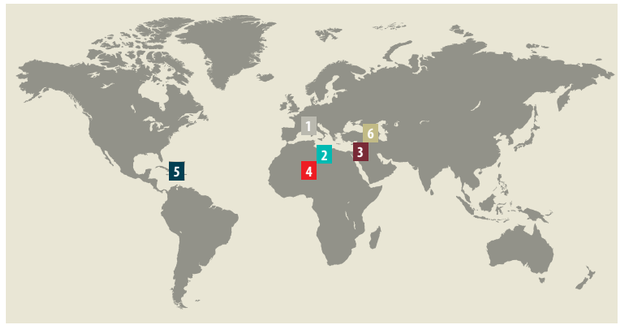
In 2015, **141,500 patients were treated for malaria by our teams in Niger**

JOIN OUR TEAM

Find out more about becoming a Médecins Sans Frontières field worker at one of our upcoming recruitment information evenings. Additional information evenings are scheduled in Australian and New Zealand cities throughout the year.

INFORMATION EVENINGS
Wed 1 Mar ***Sydney***
Tues 14 Mar ***Melbourne***
Tues 28 Mar ***Auckland***
Tues 4 Apr ***Perth***

PAST WEBINARS ARE ALSO AVAILABLE ONLINE TO WATCH ON DEMAND.
Visit **msf.org.au** for details on all our recruitment events.



1 MEDITERRANEAN

"I am filled with horror at the thought of what would have happened if this baby had arrived 24 hours earlier."

– **MIDWIFE JONQUIL NICHOLL DELIVERED A BABY ON ONE OF MÉDECINS SANS FRONTIÈRES' RESCUE BOATS ON THE MEDITERRANEAN.**
READ MORE ABOUT OUR WORK ON THE MEDITERRANEAN ON PAGE 12.

2 LIBYA

Mobile clinics in detention centres


A detention centre in Libya.
© Médecins Sans Frontières

BACKGROUND:
Libya is both a destination and place of transit for hundreds of thousands of refugees, asylum seekers and migrants who are fleeing conflict, extreme poverty or persecution. Those who are intercepted at sea by the Libyan coastguard or detained inside Libya are sent to migrant detention centres, often former factories or warehouses. Facing arbitrary detention for prolonged periods of time, people are held in unsanitary and inhumane conditions with inadequate food, water or medical care.

ACTION:
Médecins Sans Frontières is currently running mobile clinics in seven migrant detention centres in the capital, Tripoli, and its surroundings. Since activities started in July 2016, Médecins Sans Frontières has conducted 5,579 medical consultations, treating detainees for respiratory tract infections, acute watery diarrhoea, skin diseases and urinary tract infections. These complaints are mostly related to the poor and overcrowded conditions inside the detention centres. Due to the inadequate sanitation facilities, Médecins Sans Frontières has distributed hygiene kits, buckets and cleaning materials to detainees. In specific instances when food supplies have run out, making detainees more susceptible to disease and acute illness, Médecins Sans Frontières has distributed bread and cheese from local markets.

INTERNATIONAL WOMEN'S DAY EVENT SYDNEY – SAVE THE DATE


© Kate Stegeman/MSF

Sydneysiders, please join us for an International Women's Day event focusing on the topic of women's access to healthcare in Afghanistan. The free event, to be moderated by journalist Karen Middleton, will include speakers from Médecins Sans Frontières and representatives of the Australian-Afghan community.

Date and time: Evening, Tuesday 7 March
Location: Monkey Baa Theatre Company at Lendlease Darling Quarter Theatre, Darling Quarter, Sydney.

Not in Sydney? The event will be livestreamed online

Please visit msf.org.au/event/international-womens-day-2017 for updates.

3 JORDAN


A home visit for a Syrian woman in Jordan.
© Shafiq Olabi/MSF

Treating non-communicable diseases

BACKGROUND:
Non-communicable diseases – including diabetes, hypertension, asthma, cardiovascular diseases and chronic obstructive pulmonary disease – are common among Jordanian and Syrians. Treatment in Jordan is often unaffordable, particularly for Syrians who have no access to free healthcare.

ACTION:
Médecins Sans Frontières has two clinics in Irbid governorate, Jordan, near the closed border of Syria, that were set up two years ago to treat people suffering from non-communicable diseases. The two clinics have provided more than 44,000 free consultations to Syrian and Jordanian patients. This includes home visits for people who are unable to access the clinics due to a physical disability or financial constraints.

4 NIGER


Distributing malaria prophylaxis.
© Louise Annaud/MSF

Malaria cases double since 2015

BACKGROUND:
After a significant decline in malaria cases since 2012, there has been a resurgence of the disease in Niger. Following the 2012 peak, several measures to combat malaria were adopted such as distributing treated mosquito nets, implementing a preventive treatment and early detection program and epidemiological monitoring. In 2014 the number of people with malaria dropped by more than 70 per cent, however in 2016 cases more than doubled from 2015.

ACTION:
Médecins Sans Frontières teams have responded to the emergency by setting up additional health structures and recruiting temporary medical staff in the Tahoua, Zinder, Maradi and Diffa regions. Approximately 60,000 children have been treated so far. Médecins Sans Frontières is also examining the causes of this resurgence of malaria and the measures that can be adopted to fight it.

5 HAITI

Distributing building materials post-hurricane


© Jeanty Junior Augustin

A Médecins Sans Frontières logistician manager distributes aid packages in the remote areas of Jérémie and Cayes.

BACKGROUND:
On 4 October 2016 Hurricane Matthew hit Haiti, affecting over two million people along the coast and inland areas of the country. In remote areas of the mountains, people were forced to hastily rebuild by salvaging damaged materials. The poor construction quality of the buildings does not provide adequate shelter which can have direct health consequences.

ACTION:
Médecins Sans Frontières has launched a massive distribution of building materials, hygiene kits, blankets, energy biscuits, water storage equipment and water purification tablets in the remote mountainous region of Sud-Ouest, the area most affected by Hurricane Matthew, benefiting 10,000 families. Distribution has proved challenging in areas where there are no roads and security is lacking. A team of over 250 national staff and 39 international staff are still active in the post-Matthew response, in addition to the regular teams that operate in six hospitals in the capital of Port-au-Prince. Médecins Sans Frontières has also provided direct medical care in response to the hurricane, treating over 830 injured people, attending to the medical needs of 6,341 people and treating 458 cholera patients.

6 IRAQ

Increasing severity of mental health disorders


A Médecins Sans Frontières counsellor meets families to explain that mental health support is available if required.
© Brigitte Breuillac

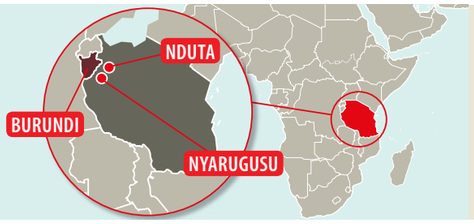
BACKGROUND:
The recent launch of the military offensive to retake Mosul, a city in northern Iraq, has forced thousands to flee. Many are extremely traumatised after enduring two years of occupation by the Islamic State. Some 30,000 displaced people are living in camps in Hassansham and Khazer, 35 kilometres east of Mosul, where Médecins Sans Frontières mental healthcare teams are assisting. Patients are suffering even more severe mental health disorders as the level of violence has escalated since the recent military offensive.

ACTION:
Médecins Sans Frontières is consulting on average 45 mental health patients a day in the Hassansham and Khazer camps, for conditions including moderate and severe depression, anxiety, acute stress reactions and post-traumatic stress disorder. Médecins Sans Frontières is the only aid organisation treating severe cases and providing psychiatric care.

TANZANIA

53 MILLION POPULATION

675 FIELD STAFF



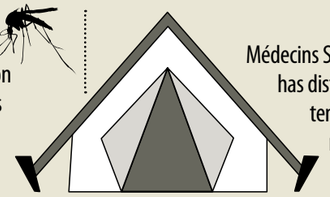
Number of Burundian refugees in Tanzania:

2016 = 180,000

2017 = 319,000

(Projected)

Malaria is the main presentation at Médecins Sans Frontières clinics in the camps



Médecins Sans Frontières has distributed 3,500 tents and 73,000 mosquito nets

OUR MEDICAL TEAM RESPONDED TO A CHOLERA OUTBREAK IN THE CAMPS, TREATING 650 PEOPLE IN 2015

MÉDECINS SANS FRONTIÈRES HAS BEEN WORKING IN **BURUNDI** FOR MORE THAN 20 YEARS AND CONTINUES TO RUN A TRAUMA CENTRE IN THE CAPITAL, BUJUMBURA

On the brink in Tanzania

A woman and her baby in Nduta camp, Tanzania.

© Louise Annaud/MSF

Resources are at breaking point as western Tanzania grapples with a huge influx of refugees from Burundi.

Hundreds of thousands of people have poured out of Burundi since May 2015, fleeing a worsening crisis. The majority have settled in Tanzania, where 180,000 Burundian refugees are now crammed into three camps. One of the camps, Nyarugusu, was already host to 65,000 people from the Democratic Republic of Congo and resources are now stretched to breaking point.

David Nash, from Sydney, is Head of Mission in Tanzania. He warns that all three camps are overcrowded, with up to 10,000 refugees arriving each month at the end of 2016. Meanwhile discussions on opening a fourth camp continue to stall.

"The current humanitarian response – especially in terms of shelter, water and hygiene – will be unable to keep up with the huge numbers of people arriving," says Nash.

By the end of this year, refugee numbers in Tanzania are expected to swell to 319,000, according to the United Nations refugee agency.

There is a real risk of outbreaks as the level of assistance fails to keep pace with the influx.

"Any deterioration in the living conditions could lead to various outbreaks such as cholera, malaria or measles," says Nash.

A breeding ground for malaria

Malaria is of particular concern as the mosquito-borne disease is endemic in western Tanzania. The crowded living conditions in the camps increase the risk of transmission, while poor sanitation, including pools of stagnant water, provides the perfect breeding ground for mosquitoes. The rainy season has also recently arrived, increasing the risk of malaria as well as water-borne diseases such as cholera. Malaria is the main presentation at Médecins Sans Frontières clinics in the camps. Between January and August 2016 – the high season for malaria – our teams in Nyarugusu and Nduta camps treated 72,644 cases, a large proportion of which were complicated cases.

Médecins Sans Frontières has been working in the camps since the first Burundians started arriving in May 2015, and has scaled up assistance in recent weeks. In Nyagurusu our teams run a 60-bed emergency room and three malaria clinics.

In Nduta camp, Médecins Sans Frontières is the main medical provider, running a 110-bed hospital and four health posts. The number of patients hospitalised with malnutrition has increased in recent weeks as food distribution continues to be threatened.

Teams screen all new arrivals to the camp for malnutrition, to ensure children are vaccinated and to check for anyone needing specific medical care, such as pregnant women. New refugees with signs of fever are immediately tested for malaria and provided with treatment.

Psychological support

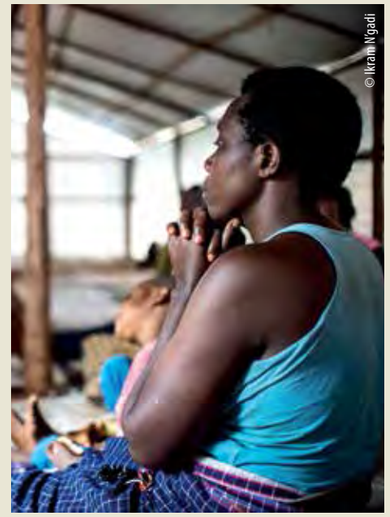
In both Nduta and Nyagurusu camps mental health specialists are providing psychological support, mostly for depression, anxiety and sleeping problems. The vast majority of mental health patients have experienced significant trauma before reaching Tanzania (see box, above right).

While Tanzania has kept its borders open in the midst of this crisis, the country needs more support to ensure it can continue to provide refuge.

"With the tensions in Burundi showing no signs of abating, it is crucial that international assistance to the humanitarian effort in Tanzania is rapidly stepped up," says Nash.

"My family was killed"

Thirty-year-old Ester fled from Bujumbura, Burundi, to Tanzania.



© Ikram N'gadi

"We were at home when an armed group raided our place. They executed my husband. I cried and ran for my life, together with my children. They shot me in the leg and I lost my children while fleeing. Only one of them could I find later. Every other family member died. I spent five months in hospital letting the doctors treat my wound before I decided to leave Burundi for good. My family was killed, my house was destroyed and all my neighbours fled. Along the journey we were facing many problems and were mainly hiding to avoid getting hurt. I could hardly walk. We arrived yesterday in Kilelema [Tanzania], without anything, as everything we had on us was stolen."

"A sense of belonging, hope and purpose"

Amanda Lam, from the Northern Territory, recently spent five months working as Nursing Activity Manager in Nyarugusu camp.

"Initially my role consisted of supervising the nursing staff of the three malaria clinics that Médecins Sans Frontières had in the camp. It then evolved to focussing on establishing an emergency department within the camp and providing one-on-one and team training. In establishing the emergency department, along with the team, I was involved in everything from recruitment and training to figuring out what stock was needed, to pharmacy management and deciding how many slots were needed in the documentation pigeon hole! To see the land transform from uneven red dirt to a fully equipped and functioning emergency department was incredible.

Once the emergency department was established, most presentations related to malaria or respiratory problems such as asthma and pneumonia, and some related to domestic violence or bike or motorbike accidents.

Most of the hospital staff were refugees. It was a real privilege to work alongside them, to play a part in recognising their potential during the interview stage and then to work together to see how we could provide an appropriate health service. It was a privilege being able to provide employment to the refugees, not only as a way to financially supplement their monthly food rations, but more profoundly to me, as a means of promoting and stimulating their social and intellectual capacities. To help provide the refugees with a sense of belonging, hope and purpose: that was one of the most fulfilling aspects of the work."

In Nduta and Nyarugusu camps, Médecins Sans Frontières has approximately 25 international staff and 650 local staff from both the refugee and host communities.

Lives in limbo in Dadaab

Twenty-five years ago, thousands of people from Somalia began to flee across the border to neighbouring Kenya to escape intensifying conflict, drought and a massive food crisis. They escaped to what has now become the world's largest refugee camp, Dadaab. Médécins Sans Frontières warns that the Kenyan Government's decision to close the Dadaab camps without offering other solutions is inhumane and irresponsible.

© Panos Moumtzis

Recently arrived Somali refugees in Dagahaley, Dadaab, wait for food distribution, May 1992.

© Brendan Bannon

Somali refugees carry their sick and malnourished children to a feeding centre run by Médécins Sans Frontières at the outskirts of Dadaab refugee camp, July 2011.

© Robert Maletta

A local Médecins Sans Frontières staff member takes the blood pressure of a patient at Dagahaley hospital, February 1999.

© Brendan Bannon

By 2011, the Horn of Africa was suffering one of the worst droughts in years, displacing thousands and killing many others. Médécins Sans Frontières opened several new nutrition centres.

© Spencer Platt

A Somali woman rests in a wheelbarrow after making a three-day journey from Somalia with members of her family, August 2009. By this stage the camps were holding three times their capacity, and lacked adequate shelter, water and sanitation services.

© Tom Maruko

The inpatient ward at Médécins Sans Frontières' Dagahaley hospital, December 2013. Médécins Sans Frontières is the only provider of medical care in Dagahaley camp with a 100-bed hospital and two health posts.

© Tom Maruko

Women and children wait at one of Médécins Sans Frontières' health posts in Dagahaley camp, March 2015. With the announced closure of the camps, hundreds of thousands of lives will be at risk due to extreme levels of insecurity and absence of medical care in Somalia.

LETTER
FROM BORNO STATE, NIGERIA

"It's like a big incubator spreading disease, particularly malaria."

Women and children wait for a consultation at Médecins Sans Frontières' clinic in Gwange, Maiduguri, November 2016.

BY HELLE POULSEN-DOBBYNS

Conflict between Boko Haram and the Nigerian army has led to massive population displacement in the northeast of Nigeria. Many people have fled to Maiduguri, capital of Borno State, where they live in precarious conditions in urgent need of food and medical care. Helle Poulsen-Dobbyns, a nurse from Sydney, recently worked as Médecins Sans Frontières' project coordinator in Maiduguri.

Helle Poulsen-Dobbyns was recently project coordinator in Maiduguri, Nigeria.

The most striking thing you notice when you first arrive in Maiduguri is the number of women and children. You do not see that many men. The reason for this is because they have either been killed or kidnapped in the conflict between the Nigerian Army and Boko Haram, or they've run away. Maiduguri is a city of children.

In our clinics, our teams were confronted with huge numbers of acutely malnourished children and an increasing number of malaria cases. In some locations malnutrition rates were as high as those recorded in conflict zones. We had both types of severe acute malnutrition: severe marasmus or wasting, and kids with Kwashiorkor (swellings of fluid known as oedema occurring on the ankles, feet, and belly), but so bad that their skin developed boil-like eruptions, as if they had suffered burns. I've never seen so many bad Kwashiorkor cases.

What we also saw during this malaria season was a lot of older children dying of malaria because they didn't have the resilience to fight the disease, due to malnutrition. Normally a 12-year-old shouldn't die of malaria because they've probably already had the disease three or four times and have developed a bit of resistance. But because of their underlying nutritional status we would see these older kids in the intensive care unit, with seizures, comatose, and stick thin. It shouldn't be happening.

It's all about food

That's why I kept telling the team "it's all about food." We targeted our food distribution to focus on the most vulnerable. For instance, when a child is discharged from the inpatient therapeutic feeding centre in Gwange, the mother is given a family ration for one month's food supply, so that that child doesn't rapidly succumb to malnutrition again. We also do targeted food distribution to families with six or more children and with at least one child under five. This targeted distribution was not intended to replace the general food distribution for the internally displaced people living in camps or in the community. But when we conducted food distribution in one camp, it was the first food these 8,000 people had received in four months.

We also distributed relief items like mosquito nets, jerry cans, sleeping mats, blankets and soap, both within the displaced person's camps and in the host community. We ran mobile clinics, screening children for malnutrition, as well as giving measles vaccinations and malaria prophylaxis.

Strengthening triage

To deal with the huge number of people presenting to our outpatient facilities, we first recruited new staff who were trained for the influx of emergency cases. Then we worked on our processes, particularly strengthening our triage system. For example, in our Maimusari clinic, we have nurses triaging within the patient queues, just walking around, checking children's temperatures, looking for those kids who are going limp in their mother's arms. Because the children were so sick, there was a risk of them dying while waiting.

Everything is against them

Unfortunately, this year's rainy season was short, with rain followed by sunshine, which creates the optimum conditions for mosquitos to breed and hatch. Whereas when it rains really heavy every day or night, the mosquitoes don't like that. At the same time you've got 90 per cent of the displaced people living outside the camps, in the community, in cramped conditions with inadequate sanitation and hygiene. So everything is against them. It's like a big incubator spreading disease, particularly malaria.

People won't return home as long as they don't have support and security. They have missed the rain and therefore the planting season. Their villages have been destroyed, livestock stolen, fields and crops looted and torched. They have got no houses to return to. There are no health services, no education.

> "It was the first food these 8,000 people had received in four months."

This crisis is still unfolding in front of us; it is far from being over. And the answers to it are simple, it's for the government and other agencies to step up their responsibility. Without nutrition, without access to water and shelter, these people are going to succumb to disease."

Médecins Sans Frontières focuses on maternal and child health in Maiduguri. The 110-bed Gwange inpatient therapeutic feeding centre admits around 300 children each month and includes an intensive care unit.

Médecins Sans Frontières also runs two large health centres in the districts of Maimusari and Bolori. Both centres include paediatric outpatient departments, outpatient nutrition centres and maternity units providing antenatal and postnatal consultations and deliveries. Maimusari also includes a paediatric inpatient department, intensive care unit and an emergency room.

In four informal camps for displaced people, a mobile team runs food distributions and offers medical and nutritional care and vaccinations. In the past three months, our teams have distributed 810 tonnes of food in Maiduguri. Médecins Sans Frontières is also trucking 80,000 to 100,000 litres of water into Maiduguri every day.

Médecins Sans Frontières' nutrition centre in Gwange, Maiduguri.

To read more letters from the field, please visit: **www.msf.org.au/stories-news**

SUPPORTER PROFILE

NAME: Lee McKerracher

HOME: Sydney, NSW

OCCUPATION: Head of Patient Relations

Lee first began supporting Médecins Sans Frontières as a Field Partner in 2005. She has also made the decision to leave a bequest in her will.

"I remember seeing a news report about the work of Médecins Sans Frontières back in 2005 focusing on how the team was the first aid agency in and generally the last to leave a conflict area. The fact that there was a team of healthcare professionals out there on the front line providing medical care to whoever needed it struck a chord with me so I decided to become a monthly donor and have been so ever since. As well as making an occasional donation to support other specific campaigns, I have also made a bequest in my Will.

Médecins Sans Frontières provides critical services in so many areas and I have so much admiration for this organisation. What stands out for me is not one particular area of work but the flexibility and adaptability of their response to whatever situation they encounter.

Not all of us are doctors, nurses or other healthcare professionals who are able to assist with the work of Médecins Sans Frontières so the next best way to ensure their work continues is to support them – even a small amount every month makes a huge difference to those in need. Thanks Médecins Sans Frontières – je t'adore!"

For more information on becoming a Field Partner, please visit www.msf.org.au

MEDITERRANEAN

MÉDECINS SANS FRONTIÈRES TEAMS TOOK PART IN MORE THAN 200 RESCUE OPERATIONS IN 2016

Médecins Sans Frontières teams worked on three search and rescue boats in the Mediterranean in 2016:
- MV Aquarius (in partnership with SOS Mediterranee)
- Dignity 1
- Bourbon Argos

FOUR BABIES WERE BORN ON BOARD OUR RESCUE BOATS IN 2016

More than **360,000** people arrived in Europe by sea in 2016. **AT LEAST 5,022 PEOPLE DIED MAKING THE RISKY SEA CROSSING**

IN 2016 MÉDECINS SANS FRONTIÈRES TEAMS DIRECTLY **RESCUED 21,603 PEOPLE** AND **ASSISTED 8,969 PEOPLE**, FOR A TOTAL OF **30,572 PEOPLE**

© Sara Creta

Dehydration, fuel burns, hypothermia and skin diseases are the main pathologies seen by our medical teams on the Mediterranean

Medical care for women on the move

© Marta Soszynska/MSF

A woman receives antenatal care on board the Bourbon Argos.

© Nicolas Castellano/SER

A woman is rescued from a wooden boat on the Mediterranean by Médecins Sans Frontières, June 2016.

From pregnancy and childbirth to the risk of sexual violence, female refugees, asylum seekers and migrants face particular vulnerabilities on their journey to safety.

Last year, Médecins Sans Frontières teams directly rescued more than 20,000 people from overcrowded boats attempting to cross the Mediterranean Sea north of Libya. While every person rescued had a story of hardship, women often face particular challenges.

Many women rescued by our teams were pregnant, and in 2016 four babies were born on Médecins Sans Frontières' rescue boats (see box, right).

Some pregnant women had not seen a midwife or doctor during their pregnancy, because undocumented migrants and asylum seekers often lack access to official healthcare. For many, the first time they had heard their unborn baby's heartbeat and received any antenatal care was in our ships' clinics. Women who are pregnant while on the move are also less likely to have access to skilled care at the time of birth, which means that if they suffer a complication like haemorrhage or obstructed delivery it is more likely to be life-threatening.

© Marta Soszynska/MSF

A baby is born on board the Dignity I.

Some of the pregnancies were very much wanted, but had simply come at a difficult time. Sadly, many other pregnancies were the result of rape in Libya, on the road, or in their countries of origin.

Risk of rape

Our teams heard horrific stories of sexual violence in Libya, particularly from women travelling alone, but also from men. Many women had been sold or forced into prostitution in Libya or on their journey. The threat of rape is so well known that some women opt to have long term contraceptive implants put in their arm before they travel to ensure they do not become pregnant.

Sexual violence also has other medical risks such as sexually transmitted infections and psychological trauma. Courtney Bercan, a nurse on the Dignity 1 ship, recently cared for a woman who was concerned she may be pregnant as a result of rape. As part of the care offered to survivors of sexual violence, she was provided with a pregnancy test confirming that she was not pregnant, treatment for common sexually transmitted infections, plus a medical certificate that she could use to press charges or seek mental health support in Europe.

"I also explained the importance of an HIV test. She nervously agreed and after 20 minutes I was able to share the good news with her," says Courtney.

"Her test was negative and given the fact that the window period for HIV to become testable had passed, she could consider herself HIV free. A wide grin spread across her face and she jumped up shaking my hands in joy. Her joy was infectious. She started to jump up and down and I couldn't help but join her."

Policies of deterrence

While this woman and many others had endured unimaginable situations, countless others never made it on to rescue boats at all. At least 5,000 men, women and children lost their lives while attempting to cross the Mediterranean Sea in 2016, while others died in Libya or during other stages of their journey. The lack of safe passage to reach Europe is pushing people to risk their lives on dangerous routes in the hand of smugglers. As the first boats of 2017 begin to make the precarious journey across the Mediterranean, Médecins Sans Frontières calls on European governments to switch from policies of deterrence to those that respect the rights of all people, regardless of nationality, to seek safety from conflict and persecution.

© Sara Creta

Bottom of the boat

Women often make the precarious journey from Libya sitting on the floor in the middle of the rubber boat. Here, seawater and leaked petrol can pool in a dangerous blend that can cause severe skin burns. If the floor cracks under the weight of the passengers, the women are then at the very bottom of the boat where they risk swallowing seawater and petrol or potentially drowning.

A new life at sea

© Alva White/MSF

Baby Newman with his mother and brother, and midwife Jonquil Nicholl, on board the MV Aquarius.

While thousands of people died attempting to cross the Mediterranean last year, the dangerous crossing also gave new life, with four babies born on Médecins Sans Frontières rescue ships in 2016.

Faith, from Nigeria, was in the very final stages of pregnancy when she was rescued from an unseaworthy rubber boat by the MV Aquarius. "I was very stressed on the rubber boat, sitting on the floor of the boat with the other women and children. Panicking that I would go into labour. I could feel my baby moving, he would move down and then move back up again. I had been having contractions for three days."

Twenty-four hours after she was rescued Faith gave birth to a healthy baby boy, Newman Otas.

Médecins Sans Frontières Midwife Jonquil Nicholl delivered the baby and described it as "a very normal birth in dangerously abnormal conditions". "I am filled with horror at the thought of what would have happened if this baby had arrived 24 hours earlier," she says.

FIELD WORKER

NAME: Malcolm Hugo

HOME: Adelaide, SA

Field Role: Mental Health Coordinator

Our mental health specialists work in both emergency and longer-term programs. Roles include working with victims of sexual violence, supporting people after a conflict or a natural disaster, or coordinating support programs for people with HIV/AIDS.

Médecins Sans Frontières Field Experience

15 assignments, including:

- 2016 Quetta, Pakistan
- 2015 Bo, Sierra Leone
- 2014 Juba, South Sudan
- 2013 Cebu, Philippines
- 2010 Haiti
- 2006 Georgia
- 2005 Banda Aceh, Indonesia

"It is fulfilling to be able to adapt evidence-based interventions in culturally sensitive and creative ways."

© Sebastian Bolesch

Malcolm Hugo talks with people affected by the tsunami in Aceh, Indonesia, in early 2005.

What led you to work with Médecins Sans Frontières?

I worked in Australia as a clinical psychologist for many years in several areas of mental health, including working with children, adolescents and adults in hospital, community and rural settings. Although the main focus of my work has been with people experiencing the more prevalent anxiety and mood disorders, I have also worked with people with psychotic disorders and those with addiction problems. My interest in working with Médecins Sans Frontières largely coincided with my reduced parenting responsibilities as my children were now independent. My first placement was for six months in Aceh following the 2004 earthquake and tsunami.

What is the most challenging aspect of work with Médecins Sans Frontières?

Making a positive difference is obviously at the top of the list, but others include being able to adapt evidence-based psychological interventions to diverse cultural settings, overcoming language barriers, knowing where to start when confronted with chaotic situations (such as in natural disasters), and working with expat colleagues with different theoretical approaches, to name just a few. One of the most rewarding aspects is providing training in psychological counselling and psychosocial interventions for the local staff, and seeing the application of their skills in the field and the development of their careers.

Could you describe the story of a patient who made an impact on you?

Perhaps the most challenging cases involve helping parents deal with the sudden death of their children due to natural disasters, conflict or disease. One such case involved a couple whose two children, aged nine and ten, had drowned due to the tidal wave caused by Typhoon Haiyan in the Philippines in late 2013. After a week or two of searching for their children (their bodies had not been found) the couple were considering ending their own lives when I first met them in the ruins of their small house. I had only met them as a result of visiting the worst hit areas and asking around about those in most need. Following our first meeting, with the help of a skilled translator (a psychologist's most valued colleague), the father agreed to let us give his loaded rifle to a neighbour for safe keeping. Their grief was overwhelming as they shared the few photographs they had managed to retrieve of their children dressed in school uniforms. I visited them daily for a couple of days and then dropped in whenever I could over the next month or so. Within a few weeks there were significant signs of recovery. Despite their grief they were more talkative, were sleeping better and were no longer considering suicide. With the assistance of neighbours, they had begun rebuilding their house and replanting their small rows of vegetables. When I last met with them they were confident that they could make a new life for themselves.

What are some of your key responsibilities with Médecins Sans Frontières?

Typical responsibilities include assessing mental health and psychosocial needs, devising a plan of action, assessing what local resources are available, and employing and training local staff. Every situation is different. Emergency contexts such as natural disasters require different interventions than more longstanding medical emergencies such as famine or protracted conflicts. It is important to be able to size up each situation and begin a service as quickly as possible. It is also important to know what type of response is required. In the immediate aftermath of a natural disaster people may be more in need of social assistance. For example, after the earthquake in Haiti and the tsunami in Aceh, Médecins Sans Frontières conducted an assessment of basic material needs and were subsequently able to distribute necessary items such as blankets, cooking utensils and clothing. We also facilitated and restored community activities such as soccer games in Aceh, playgroups for children and public meetings where people can share their experiences and ways of coping.

What advice would you give other mental health professionals who are considering work with Médecins Sans Frontières?

I would encourage other psychologists to work with Médecins Sans Frontières if they have the opportunity. In terms of advice, well, perhaps expect the unexpected. Flexibility and adaptability come to mind. Most contexts require a degree of pragmatism. You will have the opportunity to apply your therapeutic skills and it is fulfilling to be able to adapt evidence-based interventions in culturally sensitive and creative ways. You may also experience contexts where people are lacking the most basic requirements and a more psychosocial approach is needed. I think being able to adopt a practical approach and being able to take a step back and size up the overall situation is invaluable.

CURRENTLY IN THE FIELD

Note: This list of field workers comprises only those recruited by Médecins Sans Frontières Australia. We also wish to recognise other Australians and New Zealanders who have contributed to Médecins Sans Frontières programs worldwide but are not listed here because they joined the organisation directly overseas.

AFGHANISTAN
- **Jeff Fischer** — *General Logistician* — Healesville, VIC
- **Siry Ibrahim** — *Head of Mission* — Wellington, NZ

ARMENIA
- **Kerrie-Lee Robertson** — *Administration Finance Coordinator* — Marsfield, NSW

BANGLADESH
- **Arunn Jegatheeswaran** — *Field Coordinator* — Greenacre, NSW
- **Georgina Woolveridge** — *Medical Doctor* — Warrane, TAS

CENTRAL AFRICAN REPUBLIC
- **Jordan Amor-Robertson** — *Medical Doctor* — Morley, WA
- **Hugo De Vries** — *General Logistician* — Berowra, NSW
- **Caterina Schneider-King** — *Administration Finance Coordinator* — Maroubra, NSW
- **Brian Willett** — *Head of Mission* — Gisborne, VIC

DEMOCRATIC REPUBLIC OF CONGO
- **Johanna White** — *Midwife* — Porirua, NZ

EGYPT
- **Susie Broughton** — *Medical Doctor* — East Malvern, VIC

ETHIOPIA
- **Cindy Gibb** — *Medical Team Leader* — Christchurch, NZ

INDIA
- **Stobdan Kalon** — *Medical Coordinator* — Leeton, NSW
- **Virginia Lee** — *Mental Health Coordinator* — Lindfield, NSW
- **Susan Mundt** — *Nurse* — Auckland, NZ

IRAQ
- **Aiesha Ali** — *Pharmacist* — Brisbane, QLD
- **Sita Cacioppe** — *Nurse* — Naremburn, NSW
- **Emma Clark** — *Medical Doctor* — New Town, TAS
- **Jody Clouten** — *Logistician - Water and Sanitation* — Pelican Waters, QLD
- **Stephanie Davies** — *HR Officer - Regional* — Pacific Pines, QLD
- **Andrew Dimitri** — *Medical Doctor* — St Pauls, NSW
- **Kimberley Hikaka** — *Base Logistician* — Auckland, NZ
- **Malcolm Hugo** — *Mental Health Coordinator* — Payneham, SA
- **Devash Naidoo** — *Mental Health Coordinator* — Auckland, NZ
- **Jessa Pontevedra** — *Nurse* — Hamilton, NZ
- **Vino Ramasamy** — *Administration Finance Coordinator* — West Perth, WA
- **Stephanie Sarta** — *Logistician Team Leader* — Middle Park, QLD
- **Rose Stephens** — *Nurse* — Fitzroy, VIC

JORDAN
- **Gregory Keane** — *Mental Health Referent* — North Balgowlah, NSW

KENYA
- **Janthimala Price** — *Field Coordinator* — Penrith, NSW

KYRGYZSTAN
- **Graham Baker** — *General Logistician* — Woodroffe, NT

LEBANON
- **Prue Coakley** — *Field Coordinator* — Enmore, NSW
- **Louisa Cormack** — *Field Coordinator* — Apsley, VIC
- **Shelagh Woods** — *Head of Mission* — Rose Park, SA

LIBERIA
- **Jim Cutts** — *Logisitician- Electrician* — Somerville, VIC

LIBYA
- **Terry Coffey** — *General Logistician* — Rockingham, WA
- **Sam Templeman** — *Medical Doctor* — Eastwood, NSW

MALAWI
- **Rose Burns** — *Field Administration* — North Melbourne, VIC
- **Nicolette Jackson** — *Head of Mission Assistant* — Mullumbimby, NSW

MALAYSIA
- **Robert Gardner** — *Administration Finance Coordinator* — Masterton, NZ

MYANMAR
- **Linda Pearson** — *Field Coordinator* — Auckland, NZ

NIGERIA
- **Eric Boon** — *General Logistician* — Swanbourne, WA
- **Megan Graham** — *Administration Finance Coordinator* — Booleroo Centre, SA
- **Kriya Saraswati** — *General Logistician* — Prahran East, VIC
- **Sarah Scott** — *Medical Doctor* — Bairnsdale, VIC
- **Maurice Scott** — *General Logistician* — Bairnsdale, VIC

PAKISTAN
- **Catherine Moody** — *Head of Mission* — Wollongong, NSW
- **Narelle Raiss** — *Nurse* — Carlingford, NSW

PAPUA NEW GUINEA
- **Florence Bascombe** — *Nurse* — Wilston, QLD

SIERRA LEONE
- **Debra Fincham** — *Midwife* — Levin, NZ

SOUTH AFRICA
- **Ellen Kamara** — *Field Coordinator* — Beerwah, QLD

SOUTH SUDAN
- **Allen Murphy** — *Field Coordinator* — Morningside, QLD
- **Jessie Watson** — *Administration Finance Coordinator* — Gold Coast, QLD
- **Rob Baker** — *Logisitician-Construction* — Darwin, NT
- **Jai Defranciscis** — *Nurse* — Home Hill, QLD
- **Katherine Franklin** — *Medical Doctor* — Ringwood, VIC
- **Neville Kelly** — *General Logistician* — Broadford, VIC
- **Brian Moller** — *Field Coordinator* — Miami, QLD
- **Amy Neilson** — *Medical Doctor* — Sandy Bay, TAS
- **Emma Parker** — *Nurse* — Aranda, ACT
- **Keiole Rima** — *Pharmacist* — Boroko NCD,
- **Rachel Tullet** — *Medical Doctor* — Christchurch, NZ
- **Grace Yoo** — *Pharmacist* — Bankstown, NSW

SWAZILAND
- **Keith Cavalli** — *General Logistician* — South Coogee, NSW
- **Nick O'Halloran** — *Administration Finance Coordinator* — Randwick, NSW

TAJIKISTAN
- **Prudence Wheelwright** — *Midwife* — Crookwell, NSW

TANZANIA
- **David Nash** — *Head of Mission* — Cremorne, NSW
- **Elisha Swift** — *Midwife* — Nundah, QLD

TURKEY
- **Declan Overton** — *Logisitician Coordinator* — Wynn Vale, SA

UGANDA
- **Anna Haskovec** — *General Logistician* — Murrumbateman, NSW
- **Amy Le Compte** — *Midwife* — Gisborne, NZ
- **Adelle Springer** — *Epidemiologist* — Darwin, NT

UZBEKISTAN
- **Elspeth Kendall-Carpenter** — *Nurse* — Carterton, NZ
- **David Lister** — *Medical Doctor* — Ashwood, VIC

YEMEN
- **Lisa Altmann** — *Nurse* — Mount Barker, SA
- **Rodney Miller** — *Administration Finance Coordinator* — Elsternwick, VIC
- **Nikola Morton** — *Medical Doctor* — Chatswood, NSW
- **Robert Onus** — *Field Coordinator* — Chittaway Bay, NSW
- **Jessica Ramsay** — *Medical Scientist* — Perth, WA

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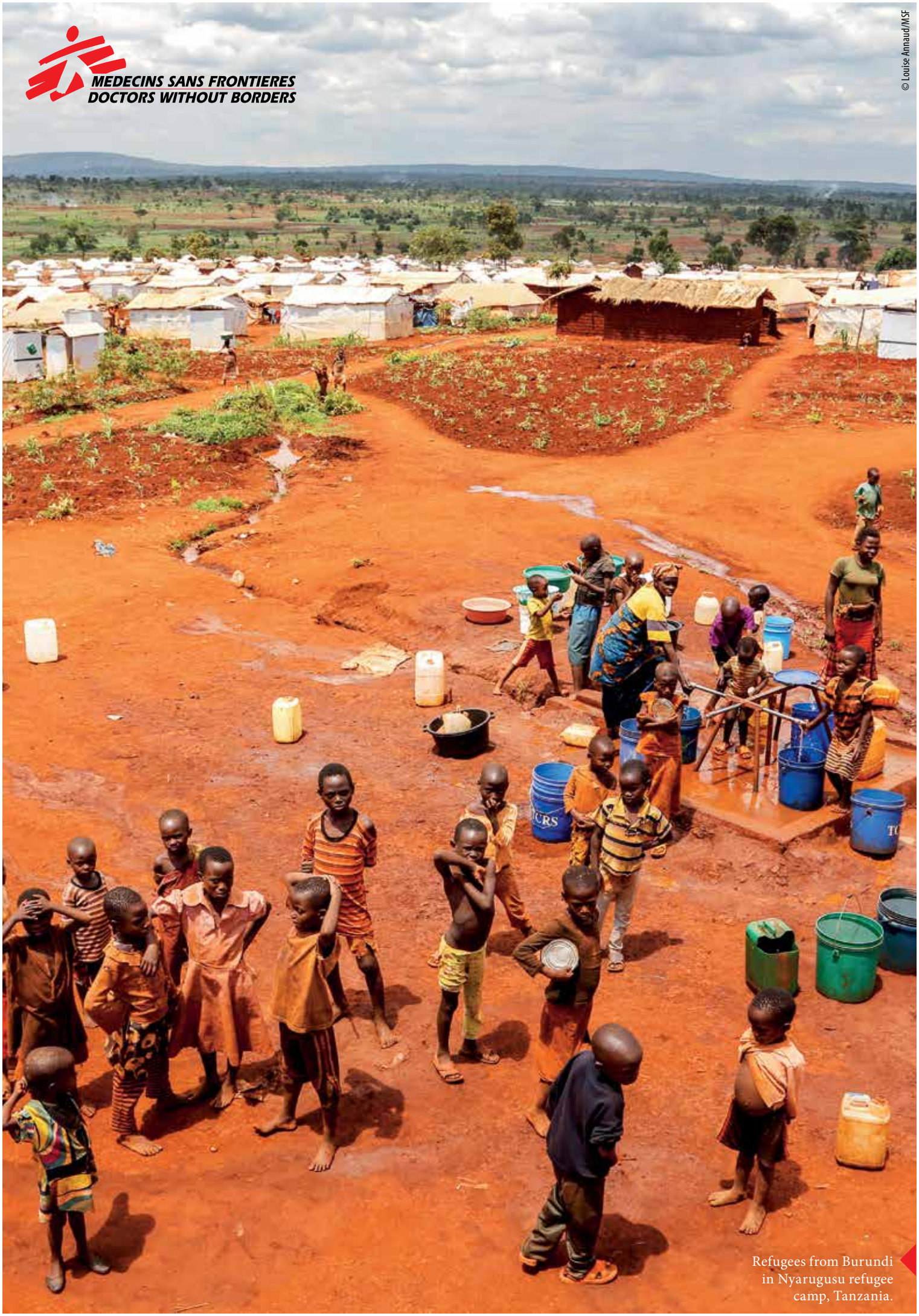
MEDECINS SANS FRONTIERES
DOCTORS WITHOUT BORDERS



Refugees from Burundi in Nyarugusu refugee camp, Tanzania.